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ABSTRACT

This paper reviews the empirical research on short-term psychodynamic psychotherapy (STDP). It begins with a brief history of STDP, identifying current developers and researchers of STDP and listing commonalities among various short-term dynamic psychotherapies. In this review, research is grouped broadly into two categories: controlled comparative studies and uncontrolled naturalistic or correlational studies. The controlled studies are further divided into studies which compare STDP with no-treatment groups and studies which compare STDP with other treatments, notably with other forms of psychotherapy. A review of these studies concludes the STDP is superior to no treatment and is generally as effective as other psychotherapies. Findings from the naturalistic and correlational studies are categorized according to the percentage of patients that were helped, the patient characteristics which correlate with positive or negative outcomes (severity of psychopathology, separation and loss issues, motivation level, interpersonal relations, object relations, response to evaluation, ego strength and dystonia of symptoms), and the potential for negative effects with STDP. Several important conclusions are drawn from naturalistic and correlational studies. The paper concludes that STDP may be appropriate for a broader range of psychopathology than many current developers of STDP have suggested, and recommends completion of further controlled studies employing specific techniques of current developers and using therapists who are experienced with STDP. (Author/NB)

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OUTCOME RESEARCH ON SHORT-TERM PSYCHODYNAMIC PSYCHOTHERAPY: A PRELIMINARY REVIEW

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OUTCOME RESEARCH ON SHORT-TERM PSYCHODYNAMIC PSYCHOTHERAPY: A PRELIMINARY REVIEW

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

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by

Scott Allyn White

May 1987

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ABSTRACT

OUTCOME RESEARCH ON SHORT-TERM PSYCHODYNAMIC PSYCHOTHERAPY: A PRELIMINARY REVIEW

Scott Allyn White

The empirical research on short-term psychodynamic psychotherapy (STDP) is reviewed. Research is grouped broadly into controlled comparative studies and uncontrolled naturalistic or correlational studies. The controlled comparative studies are further grouped according to studies which compare STDP with no-treatment groups and studies which compare STDP with other treatments. In reviewing the available controlled studies, several conclusions are made. First, STDP is superior to no treatment. Secondly, STDP is generally as effective as other psychotherapies. Several other important conclusions are drawn from naturalistic and correlational studies. Most importantly, it appears that STDP is appropriate for a broader range of psychopathology than many current developers of STDP have suggested. It is recommended that further controlled studies be completed which employ both the specific techniques of current developers of STDP and use therapists who are experienced with STDP.

Outcome Research on Short-term Psychodynamic Psychotherapy: A Preliminary Review

Short-term psychotherapies are increasingly being recognized as the wave of the future (Strupp, 1978b). Hans Strupp (1978a), one of the premier psychotherapy researchers, has delineated major external developments which are leading psychotherapists to consider short-term psychotherapies. First, he suggests that regardless of therapists' theoretical orientations, surveys consistently show that in reality most outpatient therapies are quite brief. Two recent studies confirm this supposition. Sue, McKinney and Allen (1976) completed a large-scale study which found that 69.6 percent of clinic patients dropped out before the tenth session. Similar findings are reported in a recent study of psychiatrists and psychologists in private practice, with 65 and 63 percent of the patients, respectively, terminating before the tenth session. Secondly, insurance companies and those in the health care system are stressing the need to control costs. Very often, insurance companies and health maintainence organizations (HMO) address the issue of cost-effectiveness by limiting the number of psychotherapy sessions for which they will pay.

Beyond these more pragmatic and economic pressures are developments in the field of psychotherapy research which have lead individuals to consider the viability of short-term psychotherapies. First, findings from psychotherapy outcome studies question the superiority of long-term intensive psychotherapy. Strupp (1978a) writes, "It has not been

possible to adduce convincing evidence that long-term (intensive) psychotherapy produces therapeutic results that are impressively superior; on the contrary, time-limited psychotherapy appears to be as good as unlimited therapy." He concludes that on the basis of many studies, about two-thirds of all patients will respond positively to short-term therapy. Strupp does not rule out long-term therapy, but suggests that it could be limited to those with more severe difficulties who can not be helped by briefer therapies. Secondly, findings from process and outcome research of short-term dynamic psychotherapy (STDP) have lead some to recognize the efficacy of STDP as a viable therapeutic modality. Findings related to developments in the area of STDP, such as patient selection criteria and refinement of the therapeutic process, are leading to a more systematic and refined psychotherapeutic modality (Sifneos, 1984). STDP has the advantage of being built upon both the long history of clinical insights found within psychoanalytic theory and recent studies of psychotherapeutic process and outcome (Strupp & Binder, 1984).

In light of these developments, it is not surprising that STDP is beginning to develop an increasing following throughout the world and is leading to a significant number of very recent studies. Yet, because the development and ongoing refinement of STDP is relatively new, and research in this area is largely limited to the last 5 years, no review of outcome studies has yet been published. There have been reviews of all brief psychotherapies in general (e.g., Butcher

& Koss, 1978; Koss & Butcher, 1986). However, there have been no reviews which deal exclusively with short-term dynamic psychotherapies. For this reason, this paper will provide an initial review of the outcome research on this important and developing psychotherapeutic modality.

OVERVIEW

A History of Brief Psychodynamic Psychotherapies

Peter Sifneos (1981), one of the major developers of STDP, suggests that STDP is not nearly the recent novelty that most think. In fact, Freud published case reports of early psychoanalyses in which he saw patients daily for only a few months (Flegenheimer, 1985). After this period, however, psychoanalysis became a longer and longer process. It was not until the 1920's that Ferenczi and Rank attempted to shorten psychoanalysis by developing more active techniques. Their attempt, however, was largely unsuccessful and tended to solidify the view that psychotherapy should always be a long-term treatment. During the 1940's, Alexander and French made another attempt to shorten the treatment process by developing techniques which gave rise to a "corrective emotional experience". Though they obtained some meaningful results, Alexander and French's approach was largely discredited by the majority of psychoanalytically-oriented therapists in favor of more classical long-term approaches. It is Sifneos' (1981) opinion that the psychoanalytic community continued to hang on to long-term therapy because of

its failure to distinguish between psychoanalytic theoretical principles and psychoanalysis as a treatment modality.

In the mid-1950's, Sifneos at Massachussetts General Hospital and Malan together with Balint at the Tavistock Clinic in London simultaneously began developing forms of STDP. Each independently found that well-motivated patients with circumscribed neurotic conflicts could be helped by psychodynamic interventions of a brief duration. During the 1960's and 1970's each began to systematize their approaches and empirically investigate their efficacy. Habib Davanloo at the Montreal General Hospital also developed a systematic STDP during this period. It was Davanloo who organized three International Congresses in 1975, 1976, 1977, which helped arouse wider interest and international recognition of STDP. Currently, STDP is being taught and researched systematically in various clinics and hospitals throughout Europe and North America.

Current Developers and Researchers of STDP

Short-term dynamic psychotherapy is now commonly understood to be much more than simply a shortened version of long-term dynamic psychotherapy. Contemporary developers of STDP have sought to use the insights of psychoanalytic theory to develop a largely new and well thought out form of brief psychotherapy. These developers have also sought to use findings from process and outcome research and clinical case studies to refine their techniques. While there are major similarities between how different developers have formulated

their versions of STDP, there are also qualities which are unique to each. A brief description of the major versions of STDP is presented below.

Malan (1963, 1976a, 1976b) was the first contemporary developer of STDP to describe a specific set of techniques. After an extensive initial evaluation and selection is completed, a time-limit of 20 to 30 sessions is set. The length of treatment is dependent upon the severity of the problem and experience of the therapist. The evaluator determines a meaningful focus based upon both patient dynamics and current symptomatology. Of crucial importance is the patient's ability to have adequate motivation, show an ability to relate to the examiner, and respond to a trial interpretation. Malan employs standard techniques of analytically-oriented therapies. Of particular importance are transference interpretations which establish a therapist-parent link.

Sifneos (1972, 1979) developed what he calls "short-term anxiety-provoking psychotherapy". He follows the principle stated by Alexander that the stronger the patient's ego, the more the therapist pushes material. Sifneos has delineated the clearest selection criteria in determining eligibility for his therapy. The selection criteria specify that the patient have a "delimited" chief complaint, must be psychologically minded, must be well motivated, and should have symptoms which are derivatives of an oedipal conflict. The therapist is very active and attempts to maintain a high level of tension.

Resistances are quickly confronted to maintain a high level of affect and production of "genetic material". Sifneos does not use a specific time-limit, but most patients complete therapy in 12-16 sessions. None go beyond 20 sessions.

Davanloo (1978, 1980) selects his patients by an evaluation process which is similar to a trial therapy. If the patient responds with regression rather than new material, the patient is not selected. His technique has a wide application, and he is able to treat individuals who would be rejected by other STDP's because of the severity of their psychopathology. A major feature of his technique is the therapist's relentless pursuit of the patient's even minor resistances. This mobilizes affect, especially anger. When resistance diminishes, the underlying conflicts emerge and are dealt with using standard analytic techniques. No time limit is set. Treatment may range from 5 to 40 sessions depending on the severity of the psychopathology and the experience of the therapist.

Besides those proponents mentioned above, other important proponents of STDP have also developed their own techniques. Mann (1973) developed a 12-session technique which is unique in its focus on the issues of time and termination. The newest developers of a specific technique of STDP are Strupp and Binder (1984). They have labeled their 25-30 session technique "time-limited dynamic psychotherapy" (TLDP). TLDP is similar to the therapies mentioned above yet remarkable in

the extent to which it has been developed in response to the findings from psychotherapy research.

Commonalities of Short-Term Dynamic Psychotherapies

Because the various proponents of STDP above differ in their techniques and emphases, general commonalities will be reviewed.

1. Selection and Evaluation Processes: It is generally agreed upon among those who use STDP that the short duration and active techniques make STDP unsuitable for some patients. Thus STDP requires a selection process to determine who is suitable. Among the different developers, a variety of screening criteria can be found. STDP developers also hold differing views regarding what patients should be considered appropriate for STDP.

2. Focus Upon Dynamic Core Conflicts: Most proponents of STDP suggest that the therapist should determine a central focus for the therapy. This focus should take into account an understanding of the dynamic issues which lie at the root of the symptomatology. It is also important in STDP that the therapist stick to the central focus rather than pursue other more characterological issues.

3. High Activity of the Therapist: In each of these forms of STDP's, it is important that the therapist remain relatively active in the therapy process. Because of the time limitations, the therapist must pursue the focus of the therapy and actively interpret, confront, etc., rather than wait for issues to unfold.

4. Limited Goals: Due to the time limitations, therapists using STDP generally forego goals such as extensive personality reconstruction. However, this does not mean that those espousing STDP seek symptom relief alone. For example, Malan has placed a great deal of emphasis upon measuring personality change which goes beyond symptom relief in his research. Most of those involved in STDP suggest that with appropriate patient selection, significant personality changes can occur. However, the goals are more often circumscribed to deal with a core conflict.

5. Brevity of Therapy: All STDP's are by definition relatively brief. Some set a time-limit to determine the end of therapy. For example, all clients in Mann's therapy are seen only 12 sessions, while Strupp and Binder suggest a date be set which allows 25-30 hours of therapy. Others leave the duration open-ended. Again, the length varies. Sifneos, who selects healthier patients, will not see patients more than 20 sessions. Davanloo, who deals with a wider range of psychopathology, will see individuals for up to 40 sessions. Malan, unlike most, is willing to transfer patients from short-term to long-term treatment if he determines they need further work at the end of their time limit.

FOCUS OF THE PRESENT REVIEW

The articles and books reviewed in this paper are limited to those materials written in the English language. This review is also limited to empirical studies of STDP outcome.

Therefore, studies dealing with process variables or single case studies were not included.

For the present review, "short-term dynamic psychotherapy" will be a relatively inclusive term. STDP is defined as any psychotherapy which is designated by the authors of the respective articles or books as either "short-term", "brief", or "time-limited" dynamic or psychodynamic psychotherapies. Unfortunately, some studies do not clearly describe their therapeutic procedures or distinguish which proponent of STDP, if any, after which they modeled their therapy. Thus by accepting the respective authors' labels of the types of therapies used in their studies, this review may sample a group of therapies less homogeneous than those described in the previous section. For example, all of the studies may not meet the currently recognized distinctives of STDP mentioned above. However, all of the therapies reviewed are relatively brief and employ psychodynamic techniques.

INTRODUCTION TO THE RESEARCH REVIEWED

The studies on STDP which have been conducted thus far can be divided into two very broad categorizations. The first group of studies are controlled comparative studies. These help determine whether STDP causes therapeutic improvement in patients. These studies are designed to reduce threats to internal validity, thus allowing one to isolate the effects of STDP. The second group of studies use naturalistic,

correlational, or post-hoc designs. In these studies a strong causal link between treatment and outcome can not be made.

In the present review, neither of these two groups of studies will be treated as inferior or superior. Rather, they will be viewed as complementary in the different kinds of information they provide. The controlled studies will be further divided into two sub-groups: those which compare STDP with no-treatment or minimal treatment groups, and those which compare STDP with other forms of therapy. As a whole, these groups of controlled studies give a very broad indication of the efficacy of STDP.

The other major group of studies which will be reviewed are the naturalistic, correlational and post-hoc studies. Several of these studies have been carried out by the most influencial figures in the field and have also been very important in the development and refinement of STDP. Findings from these studies will be emphasized due to their clinical relevance.

COMPARATIVE STUDIES

STDP vs Control Groups: Is STDP Better Than No Treatment or Non-specific Treatment Factors?

The first question which must be considered in evaluating the efficacy of STDP is whether it is more effective in helping patients than those who receive no treatment. As has been repeatedly shown in other outcome research, there is generally a significant degree of improvement among those who are not treated (Bergin & Lambert, 1978). This has often been

referred to as "spontaneous remission" though this may be an inadequate term for the phenomenon. Bergin and Lambert (1978), in reviewing a large group of studies, suggest that a good estimate of a baseline rate for spontaneous remission is 43% among those with "neurotic disorders". However, it is also clear that there may be considerable range of variation in this figure depending upon the type of disorder and the degree of disturbance. Therefore, in considering psychotherapy efficacy, it is not adequate just to demonstrate positive change from pre to post measures. Researchers must demonstrate that a particular type of psychotherapy is more effective than the spontaneous remission rate of the sample of patients being studied. While this has been established with many forms of psychotherapy, no literature review of has yet established that STDP is more effective than no treatment.

Six studies were found which compared the effectiveness of STDP with various types of control groups (Brodaty & Andrews, 1983; Horowitz, et al., 1984; Levene, Breger & Patterson, 1972; Sifneos, Apfel, Bassuk, Fishman & Gill, 1980; the Hamburg study, 1981; Sloane, Staples, Cristol, Yorkston, & Whipple, 1975). While several of these studies also compare the outcome results of STDP with other therapies, this section will focus upon the efficacy of STDP as it compares to the no treatment groups in these studies.

Sloane, et al. (1975) carried out one of the best comparative studies of psychotherapy outcome yet completed. Outpatients fitting in the diagnostic categories of either

neurotic (two-thirds) or personality disorder (one-third) were assigned to either short-term analytically-oriented psychotherapy, behavior therapy, or a minimal treatment wait-list group. All the therapists were very experienced psychoanalysts or behavior therapists with excellent reputations. The short-term analytically-oriented therapy basically followed the general principles of face-to-face psychodynamic psychotherapy though shortened to fit the study. Therefore, the therapy did not utilize many of the techniques thought to be essential by many of the current developers of STDP such as focus, high activity, etc.. Patients were seen for an average of 14.2 weekly sessions.

Outcome was assessed after four months of treatment and again at 1 and 2 year follow-ups. Assessment procedures included standard psychological tests, structured interviews, reports by informants, and assessment of target symptoms. Initial results revealed that both STDP and the wait-list group improved significantly on the target symptoms. However, the STDP group improved significantly more than the wait-list group. On estimates of general functioning at work and in social situations, there was marginal but not significant improvement in the functioning of each group. Yet no significant differences were found between the two groups. Blind independent assessors' ratings of global improvement revealed that while 80% of the STDP patients improved, only 48% of the wait-list group was judged improved. On a self-report measure of general adjustment, however, an equal

percentage of the two groups (77%) were rated as improved. One year follow-up results revealed maintenance of improvements with the wait-list group gradually approaching or equaling the STDP group. However, these results were confounded by the fact that all but 8 of the original 30 wait-list patients sought further treatment. Two-year follow-up results were also confounded, but results indicated that improvements remained stable.

A second major study comparing STDP with a minimal contact control group was conducted at the Hamburg University clinic (Bolz & Meyer, 1981; Burzig, Speidel, Bolz, & Meyer, 1981; Hartwig, Deneke, Meyer, Bolz, & Stuhr, 1981; Kimm, Bolz, & Meyer, 1981; Meyer, Bolz, Stuhr, & Burzig, 1981; Stuhr, Meyer, & Waltraud, 1981). In contrast to the Sloane, et al. (1975) study, this study investigated a form of STDP which much more closely followed the principles held by contemporary developers of STDP as described above. The authors labeled their form of STDP "psychodynamic conflict-centered time-limited therapy". Their techniques very closely match the techniques of Malan (1963) and Balint, Ornstein, and Balint (1972). The authors' implemented Malan's criteria to determine patients' suitability for STDP and largely used Malan's guidelines for determining a dynamic focus.

Patients were assigned to STDP, client-centered therapy, or to minimal contact wait-list groups. A design was implemented which allowed for both a reference control group comparison and an "own group" control comparison. Patients

were seen twice a week for a maxiumum of 15 weeks. Patients were seen by either experienced psychoanalysts or experienced client-centered therapists. Outcome measures included several psychological tests, a symptom check list, and ratings from a blind independent interviewer.

Only findings which suggest a clear trend by showing significant results both in the "reference control group comparisons" and the "own control group comparisons" will be reviewed. The results of the standardized psychological tests reveal several areas in which STDP produced significant results as compared to the control groups. First, STDP showed a trend in reducing patients' tendency to react physically to tension though significance was attained on only one of several measures. Secondly, "aggression" was found to become significantly higher in patients receiving STDP. However, it is unclear if there is an actual increase in aggression or simply a heightened awareness of aggressive feelings and acts. Thirdly, STDP patients showed increases in their tendency to facilitate social contact and increased their social involvement. A fourth finding is that STDP reduced patients' anxiety level. Fifthly, "depressive moods" were also found to be significantly reduced in STDP patients. Lastly, on the symptom check list, STDP was found to produce significant improvement on 11 of 157 symptoms at the end of therapy and on 20 more symptoms at follow-up. The configuration of these symptoms tended to cluster around physical symptoms of tension, sexual disturbances, and the "feeling of sinfulness".

While the studies above tend to be the most exemplary, several other studies also have addressed the question of whether patients receiving STDP gain more benefit than patients on wait lists or who receive no treatment. Sifneos et al. (1980) compared 22 patients who received "short-term anxiety-provoking psychotherapy" with 8 patients in a wait-list control group. Only neurotic individuals with circumscribed complaints who were thought to be suffering from unresolved oedipal conflicts were accepted into the study. Patients in both groups were also selected to meet various other strict screening criteria. They were seen in 9 to 20 once-a-week therapy sessions. Prior to assignment to groups, determinants of successful outcome were chosen for each patient on 9 criteria (e.g. symptoms, self-esteem, etc.). Outcome on these 9 criteria was then determined by two evaluators.

At the end of treatment, the patients received the global improvement ratings displayed in Table 1. The rating of the control group occurred at the end of the 2-5 month wait-list period. At the end of the wait-list period, control patients were also seen in STDP. While this study reveals very positive results, several methodological problems make these findings equivocal. Most importantly is the researchers' measurement of outcome. All results are based on two evaluators' ratings of patients who were not blind to the assignment of the patients' group membership. A closely related problem is the lack of measures to determine the

reliability of the two evaluators. In summary, while impressive results were found, more objective and reliable measures are needed to support these findings.

TABLE 1

Global Improvement Ratings of Patients Receiving Sifneos' STDP

	RE	MB	LB	UN
STDP (N=22)	14	4	3	1
Control (N=8)	0	0	3	4
After Treatment Control (N=7)	4	2	0	0

Note. One patient dropped out under each control condition. RE = recovered, MB = much better, LB = little better, UN = unchanged.

A study by Brodaty and Andrews (1983) compared patients receiving a very brief form of STDP, a minimal contact wait-list control group, and a group who met with their family practitioners. Patients in the STDP group saw a psychiatrist for a maximum of 8 half-hour sessions. All patients had had persistent psychological symptoms usually along with physical symptomatology for at least 6 months. On a factor comprised of symptoms and social desirability, both STDP and the wait-list group showed significant and equal improvement. On a second factor of physical disabilty and medication counts, neither group significantly improved or differed from the other in the amount of improvement. These results are difficult to interpret, however, due to a possible

intercurrent therapy effect. All patients, regardless of whether they were assigned to the control group or a treatment group, were permitted to consult with their family practitioner or any "non-psychiatric specialist" during the study. This was neither controlled for nor measured. This seems especially important to control when dealing with a sample with a high degree of psychosomatic symptoms. Secondly, patients in all groups were permitted to continue on psychotropic medication that had been prescribed prior to the study, and those in the family practitioner group were permitted to prescribe new prescriptions of benzodiazepines. Therefore, a significant amount of treatment was not accounted for in the study, leaving the results equivocal.

Another study was conducted by Horowitz et al. (1984) which examined the efficacy of STDP with patients who were experiencing pathological bereavements. A non-equivalent control group design was implemented. Those receiving STDP had sought treatment due to pathological grief reactions precipitated by the death of a parent. Those in the control group were obtained by reviewing hospital death records and then inviting adult offspring of deceased patients to participate in the study. Those in the treatment group were significantly more distressed at pretreatment measurements and were evaluated after longer periods since parental deaths (avg. 6 mos.) than control patients (avg. 2 mos.). Patients in the experimental group received a 12 session, time-limited dynamic psychotherapy designed to work through stress response

syndromes. Outcome was measured by an assessment battery and by independent evaluators who were not blind to the subjects' group membership.

The results of the study showed that after a year both groups showed significant declines in distress. Those receiving STDP had significantly steeper declines on six of the seven primary distress variables. The non-equivalent group design, however, introduced the possibility that the results might be confounded by of regression toward the mean. To control for this, a multiple regression model was used which adjusted the slope value for the initial level of distress. The only variable which continued to show significant effect was the STDP patients' greater decline in the need to actively and consciously avoid themes and emotions about the parental death.

Levene et al. (1972) compared five forms of brief psychotherapy (behavioral, Jungian, group, and two forms of brief psychoanalytic psychotherapy) and an intake-evaluation group. Patients were seen a maximum of 10 sessions by student trainees. The brief psychoanalytic therapies were simply short versions of long-term psychoanalytic psychotherapy taught by two consultants. Therapists tended to relatively inactive and used standard psychoanalytic techniques. Only one global outcome measure was used. On this measure, no significant difference was found between the STDP groups and the intake-evaluation control group. However, because the

results were inadequately measured and poorly conveyed, it is difficult to assess the meaning or validity of these findings.

Summary and Conclusion: STDP vs Controls.

In summary, there is evidence to support the proposition that STDP is more effective than no treatment or minimal contact control groups. Those studies which provided the best controls (Sloane et al., 1975 & the Hamburg study) tended to show the clearest differences between STDP and control groups. The superiority of STDP in these comparisons was shown despite the fact that in the Sloane et al. study (1975) STDP was basically a shortened version of longer dynamic psychotherapy. In the Hamburg study (1981), 12 of the 14 analysts were unaquainted with the principles of STDP prior to the study. Of the remaining four studies, two studies supported the superiority of STDP. Sifneos et al. (1980) showed a remarkable superiority of a STDP group over a wait-list group on a global rating of improvement. In the study by Horowitz et al. (1984) STDP patients showed significantly superior improvement in facing the theme and emotions of their parents' deaths than did subjects in a non-equivalent control group. However, because of the limitations of these two studies one might view these two studies as providing limited support to the efficacy of STDP. In the remaining two studies reviewed (Brodaty & Andrews, 1983; Levene et al., 1972), STDP groups were not found to be superior to control groups. These findings must also be interpreted in relation to the limitation of these studies. In the Brodaty and Andrews

(1983) study, it is difficult to determine if the lack of significant difference was due to the lack of effectiveness of only 8 half-hour STDP sessions, or due to the intercurrent therapy which may have obscured any difference in efficacy between the groups. The usefulness of the results found in the Levene et al. (1972) study are also highly suspect due to the focus of the study, the limited outcome measures, the trainee therapists used, and the nature of the STDP used.

STDP vs Other Forms of Psychotherapy: Is STDP as Effective or More Effective Than Other Forms of Psychotherapy?

A second overriding question that must be addressed when examining the efficacy of STDP is: how effective is STDP as compared to other forms of psychotherapy? Previous reviews of outcome literature (e.g., Lambert, Shapiro, & Bergin, 1986; Luborsky, Singer, & Luborsky, 1975) have often come to the conclusion that widely accepted psychotherapies and behavior therapies produce very similar results. One exception is that certain behavior therapy techniques have produced superior results with a handful of discreet problems (e.g., phobias). Therefore, for STDP to be considered a viable alternative psychotherapy modality, it is important to establish whether or not STDP is as effective as comparable forms of psychotherapy.

Seven studies compared STDP to other forms of psychotherapy (Bassett & Pilowsky, 1985; Piper, Debbane, Bienvenu, & Garant, 1984; Brodaty & Andrews; 1983; Levene, Breger, & Patterson, 1972; Strupp & Hadley, 1979; Sloane, et

al., 1975; and the Hamburg study, 1981). Several of these studies were also mentioned above contrasting STDP with control groups. This section, however, will focus specifically upon the efficacy of STDP as contrasted with other treatment groups.

Two of the major well-controlled studies discussed above compared STDP to other forms of psychotherapy. Because these studies were extensively discussed above, only the results of the comparisons among treatments will be explored. Sloane et al. (1975) compared the efficacy of STDP with behavior therapy (BT) as well as the wait-list control group. The behavior therapists included recognized experts such as Arnold Lazarus and Joseph Wolpe. On a measure of severity of target symptoms, both the STDP and BT groups improved significantly more than a wait-list/minimal treatment group. However, there was no significant difference between the two therapy groups. Only the BT group showed significant improvement over the control group on a measure of work adjustment. However, no significant difference on work adjustment was found between STDP and BT. On a measure of social adjustment, no significant difference was found between the two therapies, though behavior therapy was the only one of the two to reach significance in the pre to post measure of improvement. A global rating of improvement by blind independent assessors showed 80% of both therapy groups as improved. However, on an objective rating of general adjustment, more BT patients (93%) were rated as improved or recovered than STDP patients

(77%). At a one-year follow-up, while both STDP and BT groups were found to have significantly improved on each of the three variables (target symptoms, work adjustment and social adjustment), no significant difference was found between the two groups. The authors concluded that neither therapy was shown to be more effective than the other, though a slight trend was present for BT patients to show some improvements earlier.

In the Hamburg study (Bolz & Meyer, 1981; Burzig, Speidel, Bolz, & Meyer, 1981; Hartwig, Deneke, Meyer, Bolz, & Stuhr, 1981; Kimm, Bolz, & Meyer, 1981; Meyer, Bolz, Stuhr, & Burzig, 1981; Stuhr, Meyer, & Waltraud, 1981) discussed above, STDP was compared with client-centered psychotherapy (CC) and a wait-list group. On self-report measures, CC tended to be superior to STDP on some measures at the posttest and at the 2-year follow-up . The STDP group, in contrast, had significantly higher levels of "aggression" though it is unclear if this was due to higher rates of aggressive behavior or simply a greater awareness of aggression. On a 157 item symptom check list, CC was superior to STDP on 12 items which clustered around factors of physical tension and self-esteem. STDP was superior to CC on 3 items which concerned "sex disturbance", the "feeling of sinfulness", and "giving in too easily".

Eight psychoanalysts blind to the treatment conditions also rated patients' improvement on 31 variables at three month and nine month follow-ups. Twenty-four variables

reached a sufficient level of inter-rater reliabilites. These variables fell into three main groups concerning "insight", "symptom change", and "changes in personality and human relations". The STDP group was found to be significantly superior to the CC group on variables (three at three months, and four at nine months) measuring insight. At the first follow-up, CC showed a significant superiority on minor symptoms though only one measure continued to be significant at the second follow-up. Lastly, on "changes in personality and human relations" variables, CC was superior at nine months on "attitude to own self" while STDP was superior at three months on "introspection". On global ratings, CC was superior on overall changes, and significantly more patients in the CC group felt therapy helped at nine months.

In summary, both therapies showed significant superiority on different scales among variety of measures used. Most often no difference was found between the two treatments. Yet, it does appear that the CC group was superior on more scales more often. The researchers summarized their findings in this way: "If our comparison were the Olympic games and statistical significance were bronze, silver and gold medals, it would be quite obvious that CC has won more medals" (Stuhr, Meyer, & Bolz, p. 196-197, 1981). However, they also accurately suggest that the number of significant differences is quite small in relation to the very large number of scales and symptoms measured.

A third well-controlled study (Piper, Debbane, Bienvenu, & Garant, 1984) compared STDP, long-term individual, and short-term and long-term group psychotherapies. All were psychoanalytically -oriented psychotherapies conducted by three experienced psychiatrists. Those in individual therapies met once a week for 55 minutes while those in the group therapies met once a week for 90 minutes. Long-term patients were seen up to two years (average 76 sessions), and short-term patients were seen up to six months (average 22 sessions). The STDP employed the techniques described by Malan (1963, 1976a). The patients had been referred for outpatient psychotherapy, and 66% received a DSM-II diagnosis of neurosis while another 30% were diagnosed as mild or moderate personality disorders. Patients were matched by age, sex, and various selection criteria ratings.

Results were measured every six months and concluded at six months after the end of the therapy. Outcome measures covered interpersonal functioning, psychiatric symptomatology, and personal target objectives. Outcome measures included: patient self-reports, objective personality tests, therapist ratings, and ratings by blind, independent assessors. Significant evidence was found for a type (individual vs group) X term (long vs short) interaction effect. The six significant posttreatment measures revealed a consistent pattern. From the patients' perspective, long-term group (LTG) therapy was rated best, STDP was a close second, long-term individual (LTI) was third, and short-term group

(STG) therapy was a distant fourth. From the therapists' perspective STDP was rated first, followed closely by LTI and LTG, and STG was again a distant fourth. Scores at follow-up revealed that gains were maintained and that these patterns remained consistent at follow-up though in a weaker form. Overall, results seemed to indicate that the best outcomes were associated with LTG and STDP while the worst outcomes were with STG. This is in contrast to the therapists' initial outcome biases, which they believe would have favored long-term individual therapy. Therapists in the study reported that with STI patients tended to work hard and quickly, attention was concentrated, and affective involvement was high. In contrast, with LTI therapists felt that the one session a week favored an increase in resistance and greater restriction of affective expression from patients.

Another important and very well-controlled study was conducted by Strupp and Hadley (1979). They contrasted the effectiveness of experienced therapists with a select group of college professors. Thirty-five college males were seen either by experienced analytically- or experientially-oriented psychotherapists or with one of several popular college professors. All of the subjects were selected to fit an (2-7-0) MMPI configuration and presented with depression, anxiety, and social introversion. Patients were offered up to 25 sessions of therapy on a once- or twice-a-week basis. Change was measured by the MMPI, patients', therapists', and clinicians' ratings of changes in target complaints,

self-rated overall change, and experts' ratings on clinical scales of disturbance. Comparisons between the three groups revealed the following: There were no significant differences on any of the six measures based on the patient's own perspective, nor on therapist measures of change, nor on ratings of the groups. All three groups were, however, more improved than either a minimal contact or so-called "silent" control group. It was found that theoretical orientation and professional - nonprofessional status did not have an impact on the outcome though it did effect the therapeutic process (Gomez-Schwartz, 1978). Also, it was found that therapy outcome was most consistently predicted by the patient's willingness to become actively involved in the therapy interaction.

Several other studies with serious limitations due to inadequate design and/or controls have also compared STDP with other forms of psychotherapy. Bassett and Pilowsky (1985) compared the efficacy of STDP and supportive psychotherapy with pain patients. The supportive therapy used cognitive strategies, advice, and supportive listening. The STDP was simply a shortened long-term dynamic psychotherapy. Those receiving STDP were seen for 12 weekly one-hour sessions while the supportive therapy consisted of only meeting six times for half-hour sessions every other week. Results of the study showed a trend for STDP to be superior, reaching significance on only one measure at a 12 month follow-up. Fewer STDP patients dropped out of treatment (23% to 56%), and more felt

STDP helped them cope with their pain (54% to 22%) than with the supportive therapy. However, the results are highly equivocal due to the high and differential drop-out rates, the low percentage of data collected which resulted in very small samples, and lack of control for experimenter bias.

Brodaty & Andrews (1983), compared STDP with a "family practitioner therapy". The family practitioner therapy consisted of listening, advice, and medication. The STDP was patterned after the techniques of Malan (1963, 1976a), Balint, Ornstein, & Balint (1972), and Sifneos (1972). Eight half-hour sessions were given under both conditions. No significant difference was found between the two groups on any measure. As discussed above, however, it is difficult to assess if the lack of significant results in this study was due to the confounding of effects of intercurrent therapy. The uncontrolled treatment which crossed both therapies, particularly the psychotropic medication, may have accounted for the positive findings within each condition and obscured any differences between the two therapies being studied.

The study by Levene et al. (1972) briefly described above compared five brief psychotherapies provided by trainees. The five forms included two forms of STDP, Jungian therapy, behavior therapy, and group therapy. The STDP's were experimental therapies which were simply shortened versions of long-term analytic therapy. All patients were seen for up to a maximum of 10 sessions. No significant differences were found between any of the forms of therapy. However, one of

the STDP groups was found to consistently score the worst or nearly the worst on all measures, including the intake-evaluation group. The second STDP group also consistently did poorly in relation to the other forms of therapy. A general trend showed that more active therapies produced greater improvement. Interestingly, the forms of STDP used in this study lead therapists to be the least active of the five therapies. These findings suggest that when STDP is poorly done and/or if a therapist remains highly inactive during STDP, STDP may be quite ineffective. However, because the results were inadequately measured and poorly conveyed, it is difficult to assess the full meaning or validity of these findings.

Summary and Conclusion: STDP vs Other Psychotherapies

As a whole, the group of studies reviewed above reveals results quite similar to most reviews of comparative studies. In general, the forms of STDP reviewed produced rates of improvement similar to other forms of psychotherapy. Some studies generally found no significant difference between STDP and other forms of psychotherapy (Strupp & Hadley, 1979; Brodaty & Andrews, 1983, Levene, et al., 1972). Various other studies revealed a slight superiority of STDP (Piper, et al., 1984; Bassett & Pilowsky, 1985;). And yet other studies have revealed either a slight superiority (the Hamburg study, 1981) or earlier effects (Sloane, et al., 1975) with competing psythotherapies.

Examining the studies reviewed by breaking them down into more discreet categories does not appear to change the general findings. If one includes only the results of the best controlled studies (Strupp & Hadley, 1979; Piper, et al., 1984; the Hamburg study, 1981; and Sloane, et al., 1975), the same pattern of results is found. Similarly, looking at only those studies which employed techniques similar to those espoused by current developers of STDP (Brodaty & Andrews, 1983; the Hamburg study, 1981; and Piper, et al., 1984) reveals the same pattern of equal, less effective and more effective results. Compared to specific therapies, STDP was found to be either equal to (Strupp & Hadley, 1979) or slightly inferior (the Hamburg study, 1981) to client-centered or experiential psychotherapies. STDP was also found to be equally as effective as behavior therapy (Sloane, et al., 1975) though it was found that behavior therapy may be more effective with a broader range of patients and may lead to positive results sooner. Compared to other analytically-oriented therapies (Piper, et al., 1984), STDP was found to be equally as effective as long-term group therapy, slightly superior to a two-year long-term individual therapy, and significantly superior to short-term group psychotherapy. Therefore, reviewing the data in relatively broad terms, STDP is generally as effective as other traditional forms of psychotherapy. This is consistent with most reviews of outcome research with other forms of psychotherapy. While various studies reveal significant

differences, either superior or inferior on a limited number of measures, neither a clear pattern of superiority nor inferiority can be claimed.

The Limits of Traditional Research Methodology with STDP

The studies reviewed above which employ traditional research methodology offer important information to the clinician about the general efficacy of STDP. However, many have criticized this kind of traditional outcome research as being of limited value to clinicians (e.g., Lambert, Shapiro, & Bergin, 1986). One of the major shortcomings of much of traditional outcome research is that the only results conveyed are significant differences between group means. This data is often not particularly helpful to the clinician for several reasons. Firstly, by reducing findings to group means, the effect of the treatment on the individual is obscured. Group means do not reveal how many of the patients were found to be significantly helped, what types of individuals were helped, and in what ways patients changed. Secondly, statistical significance does not guarantee clinical significance. Though a measure may achieve statistical significance, patients and clinicians may not find the results particularly significant in light of patients' psychological distress. Thus, alternative research designs and creative analyses of data are needed to make research findings more relevant to the clinician. In the following section, studies of STDP using alternative research designs will be examined to address more

specific questions which might be of interest to the clinician.

Naturalistic, Correlational and Post-hoc Studies: Clinically Relevant Findings

Now that the general efficacy of STDP has been established by examining traditional outcome research design, it is crucial that research results which are more relevant to the clinical application of STDP be explored. Many findings which are particularly relevant to the clinician can be obtained from non-controlled studies and post-hoc analyses. In fact, the majority of studies completed by the current developers of STDP are naturalistic and correlational studies. These designs allow researchers to study both process variables and specific outcome results. These designs also assist researchers in determining how STDP affects different individuals with different problems. Because of the uncontrolled nature of these studies, however, they do not unequivocally determine causality or completely rule out competing explanations of the findings. Yet, some inference of causality may be hypothesized, while also revealing further information which is clinically useful.

Below, findings from these uncontrolled studies will be categorized according to the percentage of patients that were helped, the patients characteristics which correlate with positive or negative outcomes, and the potential for negative effects with STDP.

Percentage of Patients Helped with STDP

It is often helpful for clinicians considering the use of STDP to have some idea of what percentage of patients will improve and to what degree. Several studies have divided their subject sample into broad categorizations related to the degree to which the therapy was successful. In Table 2, categorizations used by each author are presented along with the percentage of patients judged as belonging in each category. Because these various studies used different patient samples, the studies are further grouped according to the range of psychopathology included in the patient samples.

Two studies (Table 2) looked at the effects of STDP on patients diagnosed as having a range of diverse psychiatric disorders. Malan (1976a) performed a pioneering naturalistic study of process and outcome with STDP. Patients with a variety of disturbances from neurotic disorders to personality disorders were seen. The onset of patients' problems ranged from several months to many years prior to treatment. Most of the 39 patients were seen for between 5 and 50 sessions though several were referred for long-term treatment. Outcome was determined by the average rating of four independent judges. Judges rated patients five to six years after therapy to help determine if changes produced in short-term therapy would be enduring. Results are broadly categorized in Table 2. Judges determined that only those in the top three categories should be deemed successful therapies. Overall, the therapy of 64% of the patients was judged to be successful while 36% was

judged unsuccessful. Another study by Mohl et al. (1982) studied the effects of STDP on medical students with a variety of psychiatric disorders. In contrast to Malan's study, no patient was seen for more than 10 sessions. As shown, 33% were judged successful by demonstrating the following; intellectual and emotional insight, significant working through of their primary problems, behavioral change, and awareness of their own progress.

TABLE 2

Improvement Ratings of Subjects Receiving STDP in Naturalistic Studies

MIXED DIAGNOSES

Malan (1976a)

Recovered	Much Improved	Improved	Slight/Moderate Improved	Unchanged
7%	33%	37%	20%	0%

Mohl et al. (1982)

Successful	Partial Success	Unsuccesful
33%	33%	33%

NEUROTICS

Sifneos et al. (1980)

	Recovered	Much Better	Little Better	No Change
	64%	21%	11%	4%
Pilot	0%	74%	13%	13%

Husby et al. (1985)

	High SIP & Symptom Relief	Symptom Relief Only	Both Low
2 Yr FU	31%	67%	33%
5 Yr FU	49%	30%	21%

LOSS AND TRAUMA

Horowitz et al. (1986)

	Excellent	Good	Fair	Poor
1 Yr FU	32%	36%	16%	16%
5 Yr FU	62%	19%	15%	4%

Lindy et al. (1983)

Complete	Interrupted	Non-engaged
33%	50%	17%

Another two studies (Table 2) looked at the effects of STDP with neurotic patients. Some researchers (e.g., Sifneos) believe that STDP should be limited to higher functioning neurotics due to their more confrontive techniques. In two

studies by Sifneos et al. (1980), neurotic patients with a variety of symptomotology were seen for two to five months in STDP. Patients were rated by two evaluators on nine outcome scales, including a measure of internal dynamic changes. Global evaluations in both studies revealed a large percentage (85% and 74%) of the patients being designated as either "much better" or "recovered". A similar study with patients with "neurotic personality structures" was also conducted by the Oslo group in Norway (Husby et al., 1985; Husby, 1985a, 1985b). Patients were seen for an average of 20 sessions in a form of STDP patterned after Malan's and Sifneos' techniques. Researchers divided the outcome measures between two broad categories: symptom relief and specific internal predisposition (SIP). The SIP measure was taken from the work of Malan (1976a) and is thought to measure stable changes in internal dynamic conflicts which lie at the root of the symptomatic problems. A greater portion of patients experienced symptom relief than change in their specific internal predisposition. Consistent with the SIP conceptualization, 82% of those who scored high on SIP at two years maintained their improvements at five years.

Two other studies (Table 2) have looked at the efficacy of STDP with patients experiencing significant loss and trauma. Horowitz et al. (1986) studied the effects of STDP with patients experiencing complicated bereavements due to the loss of a parent. Patients were seen for up to 12 sesions. Measures of distress were entered into a decision rule

algorithm that lead researchers to categorize patients into one of four groups. Prior to treatment evaluations, 91% of patients were categorized as either fair or poor. However, at a one-year follow-up 81% of the patients were rated as either excellent or good. Lindy et al. (1983) conducted a naturalistic study of 30 patients who were survivors of the 1977 Beverly Hills Supper Club fire disaster. These patients were also seen for a maximum of 12 sessions. At a one-year follow-up, both those who were judged as completed (Avg. 9.4 sessions) and those whose therapies were determined to be interrupted (Avg. 4.9) were found to show subclinical levels of disturbance.

Because of the diversity of measures, categorizations, lengths of treatment, and types of problems, the data above can not be collapsed into a singular figure of efficacy. However, it does appear that STDP has been shown to be effective with a significant percentage of patients. Because of the limitations of the research designs, it is impossible to determine if the results found in the studies above are a result of STDP or other factors (e.g., spontaneous remission). Yet, the severity and duration of many of the patients' problems support the view that STDP was at least partially involved in the change process.

Patients Most Likely To Benefit from STDP

By reviewing the data (Table 2), it is clear that different patients receive different degrees of help from STDP. For the clinician, the question that naturally follows

such findings is: "How can one distinguish those who will benefit from STDP from those who will not?" A variety of patient variables have been correlated with poor and positive outcome results and will be reviewed below. First, those variables which have been correlated with poor results with STDP are delineated.

Severity of Psychopathology. A relationship between severity of psychopathology and poor outcomes is indicated in the research reviewed. It is not, however, a simple relationship which correlates poorer outcomes with more severe psychopathology. The body of research reviewed supports Malan's (1976a) analysis that there is a complex relationship between severity of pathology and outcome. He concluded that though therapy failures were partly due to severe psychopathology, some individuals with severe psychopathology were significantly helped.

It appears that the most conclusive determination that can be made from available studies is that those patients with personality disorders tend to do more poorly in STDP. Horowitz et al. (1986) found that a disproportionate number of patients with severe personality disorders had fair or poor outcomes. The findings of Free et al. (1985) may also support this conclusion. They discovered that the best predictor of outcome was how patients scored on pretherapy measures. Interestingly, 46% of the patients in their study were given diagnoses of personality disorders. Thus, those with poor pretreatment measures may largely have been those with

personality disorders. Another study which supports this hypothesis is a study by Keller. She found that those who did most poorly in STDP were "those who functioned less well in their daily lives and yet were less distressed by their disturbance" (1984, p. 351). This characteristic is, by definition, typical of many individuals diagnosed with personality disorders.

Separation and Loss Issues. Sifneos et al. (1980) in their pilot study, found that those patients who were found to have experienced little benefit from his form of treatment were patients whose focus related to separation and loss issues. He suggests that termination issues often exacerbate the partially unresolved conflicts resulting in reemergence of psychological difficulties. However, this phenomenon may not be typical of all STDP techniques because some STDP proponents (e.g., Mann, 1973) focus much more on termination issues.

Low Motivation. Sifneos et al. (1980) also found that those patients who experienced the least degree of change during STDP were patients with low motivation for change. Researchers retrospectively determined that these patients were improperly assessed during the intake evaluation as motivated to change.

Research has also demonstrated that several other patient characteristics appear to be related to positive therapy outcomes. These include:

High Motivation. The variable which most clearly correlates with positive outcome is high motivation in the

treatment process. Malan (1976a) looked at seven different criteria for patient selection. Only "high motivation for insight" positively correlated with favorable outcomes. Husby (1985a) found that high motivation was positively correlated with change in patients' "specific internal predisposition" or internal dynamic changes. Keller (1984) also found that several measures which related to patients' motivation to work in insight-oriented therapy correlated with successful treatment outcomes.

Current Interpersonal Relations. Keller (1984) found a relationship between positive outcome and the presence of a positive supportive relationship in the patients' lives. It was her hypothesis that a positive supportive relationship may be needed to help complete the working through process after the completion of treatment.

Past Object Relations. There are conflicting findings regarding whether a patients' history of object relations correlates with positive outcome. Husby et al. (1985) found that if a patient had at least one give-and-take relationship in his or her history, the patient was more likely to have a positive outcome. Keller (1984), on the other hand, found no correlation between outcome and "early deprivation and severity of damage to object relations". Similarly, Malan (1976a) found no correlation between "history of satisfactory personal relations" and positive outcome. From these diverse findings, it is difficult to come to a conclusion about the importance of past object relations and positive outcomes.

However, it may be that Husby et al.'s (1985) finding suggests that at least a minimal capacity for object relations, as shown by a history of at least one give-and-take relationship, is needed for positive results with STDP.

Response to Evaluator. There are also conflicting findings regarding the use of patient responsivity during initial evaluation for the prediction of outcome. Husby et al. (1985) found that adequate interpersonal "contact" with an evaluator was correlated with a positive outcome. However, Malan (1976a) found no correlation between outcome and a patient's response to a trial interpretation during the initial interview. It may be that a patient's ability to emotionally relate to an interviewer during an evaluation is more important than how the patient responds to the interviewers' conceptualization of the patients' problems.

Ego Strength and Dystonia of Symptoms. Keller (1984) found that those patients who "suffered from a high level of distress from psychological disturbance yet who function well in spite of it tended to do much better in therapy". She suggested that this might be understood as a relationship between ego strength and the degree to which patients' symptoms are ego dystonic.

Several other important variables were found to correlate neither positively nor negatively with outcome. Perhaps most significantly, outcome has not correlated with the length of time since the onset of patients' problems (Keller, 1984; Malan, 1976a; Husby et al., 1985). Outcome also did not

correlate with socio-economic status (Husby et al., 1985), mild and circumscribed psychopathology (Malan, 1976a), or "sound basic personality" (Malan, 1976a).

The Dangers of Negative Effects with STDP

The term "negative effect" has been suggested (Strupp, Hadley, & Gomez-Schwartz, 1977) to describe the general finding that a certain portion of psychotherapy patients are sometimes found to be worse after treatment. There is controversy, however, regarding whether the worsening should be considered as causally linked to the therapists' activities (Lambert, Shapiro, & Bergin, 1986). The measurement of negative effects seems particularly important with patients receiving STDP for several reasons. First, because some forms of STDP (e.g., Sifneos' & Davanloo's) attempt to confront resistances and raise anxiety, there has been greater concern to screen out patients that might deteriorate in response to these techniques. Secondly, because STDP is brief, one might be concerned that a patient's treatment may be incomplete at termination and in some way exacerbate the patient's distress. Because of these concerns, most proponents of STDP have stressed the need to screen patients to reduce the possibility of negative effects. All suggest that those patients with the most severe and difficult disorders such as thought disorders, addictions, and sexual deviations not be seen in STDP. However, beyond these generally accepted limits, various proponents of STDP are more or less restrictive in their screening processes.

Of the studies reviewed, only four studies (Table 3) attempted to measure whether any patients were found to be worse after therapy than before therapy.

TABLE 3

Negative Effects Upon Patients Receiving STDP

STUDY	SAMPLE	NEG EFFECT
Malan (1976a)	30	1 patient = 3%
Husby et al. (1985)	36	0
Krupnick & Horowitz (1985)	7	1 patient = 14%
Basset & Pilowsky (1985)	13	1 patient = 8%

Malan (1976a) found only one patient who showed signs of deterioration at follow-up. This patient, who completed only five sessions, attempted suicide prior to his follow-up evaluation. Upon further evaluation, Malan determined that the patient was misdiagnosed and showed "bisexual, manic-depressive, and possibly borderline features" (p.266). Krupnick and Horowitz (1985) completed a post-hoc analysis of 7 patients determined to be "vulnerable" to either narcissistic or borderline disorders. Patients were seen for 12 sessions. At follow-ups, one patient showed "some deteriorization and greater disorganization". However, none of these patients with these severe disorders had psychotic decompensations, had to be hospitalized, or attempted suicide. Bassett and Pilowsky (1985) studied the effect of 12 sessions of STDP with pain patients. On a global measure of change,

one patient was found to be doing worse on a posttreatment measure, two patients at six months, and one patient again at 12 months. In contrast to these three studies, Husby et al. (1985) found that no patients scored worse on any measure at either the two-year or five-year follow-ups.

To evaluate these studies as a group, one must consider the diversity of patients studied. The study (Husby et al., 1985) using the least disturbed patients (neurotics) found no negative effects. Malan's study (1976a), which included those with a broader range of psychopathology, found that only 3% of the patients showed signs of deterioration. In contrast to this, Krupnick and Horowitz (1985) intentionally set out to include patients which most say are too disturbed for STDP. Surprisingly, only one of these patients showed mild deterioration. In summary, the studies available seem to suggest that the potential for negative effects from STDP may not be as great as some have feared. Very few patients are likely to become worse after STDP when conventional screening criteria are used. With patients with more severe psychopathologies who are usually excluded by conventional screening criteria, the risk is greater but still seems to remain relatively small. No studies, however, have included patients with thought disorders, addictions, or sexual deviations. Clinical wisdom seems to suggest that there might be a lesser risk of deterioration when those with more severe personality disorders are seen in long-term therapy. However, it appears that the clinician need not greatly fear that STDP

will necessarily cause harm to patients with these more difficult disorders.

Conclusions and Recommendations

In light of the research reviewed, conclusions and recommendations will be made regarding further research and clinical applications of STDP.

First, conclusions and recommendations can be made regarding further research efforts. Firstly, more well controlled studies are needed which employ both the specific techniques of current developers of STDP and use therapists who are experienced with STDP. To date, only one of the better studies employing a between group design (Piper et al., 1984) has combined these two important factors, yet even this study is lacking a control group. Too often the therapies in the controlled studies have simply been shortened versions of long-term dynamic therapy and/or have used therapists not experienced in the techniques of STDP. Therapists in many controlled studies are experienced only in long-term dynamic therapy. Because STDP requires a new set of techniques, however, it is questionable whether those familiar only with long-term therapy can do justice to this more active therapy. Secondly, further naturalistic and correlational studies are needed to explore the efficacy of STDP with patients having a greater variety and range of psychopathologies. The research reviewed suggests that STDP is applicable to a wider range of psychopathology than some have previously believed. Future studies should further explore the efficacy of STDP with

specific disorders, especially those deemed more severe than "neurotic" disorders. Lastly, comparative studies between forms of STDP should be carried out to discover if there might be an interaction between specific forms of STDP and efficacy with certain types of disorders and/or severity of psychopathology. For example, it might be determined whether a form of STDP like Mann's that is less confrontive and deals with termination early in therapy might be most helpful with more disturbed patients.

Conclusions and recommendations related to clinical application of STDP can also be made from the research reviewed. The findings are at times confirming and at other times disconfirming of the intuitive and theoretical biases of the current developers of STDP. Several general findings seem especially important. Firstly, it has been shown that STDP can produce significant improvements that remain stable over long periods of time. It also appears that many patients continue to improve after termination of therapy. This may suggest that some of the working through process which takes place during long-term therapy often occurs after therapy with patients receiving STDP. To assist this working through process after therapy, there is evidence that it is helpful for patients to have at least one significant relationship in his or her life. A second finding is that while all patients do not recover with STDP, a significant percentage of patients were found to have had successful treatments. Related to this, it appears that patients with the greatest resources or

the least severe problems prior to therapy are often able to gain the greatest help. This is similar to findings with other therapies. A third significant finding is that STDP appears to be effective with a broader range of psychopathology than some developers of STDP have suggested. Evidence does not suggest that STDP should be limited to patients with circumscribed problems, a recent onset of difficulties, oedipal issues, or a neurotic personality structure. Many individuals with long-term and relatively severe problems have received considerable help with STDP. It is true that those with more severe problems, such as personality disorders, may have a poorer chance of recovery and a slightly higher risk for deterioration. However, this would likely be true with any form of psychotherapy. For example, Keller (1984) found that those who had unsuccessful treatments in STDP went on to have unsuccessful treatments with long-term therapy. A final finding is that generally very few individuals show signs of deterioration after STDP. This finding contradicts the assumption by some who believe that the high activity of STDP may make it inappropriate for many patients. There could, however, be an interaction between the type of STDP, the severity of a patient's psychopathology and negative effects. Therefore, it remains unclear if the most confrontive techniques might, as some suggest, be contraindicated with some patients with more severe psychopathologies. Further research is needed to clarify this question.

Because most of the research on STDP is relatively recent, it is unclear to what extent empirical research has impacted the present practice of STDP. Perhaps the study which has had the greatest impact on the field to date is the study by Malan (1976a). His findings regarding the effectiveness of STDP with more disturbed patients and key techniques (i.e., parent-child-therapist interpretations) have been widely cited and implemented. Though developers of STDP emphasize the need for empirical findings to impact the clinical use of STDP, there appear to be factors which may hinder this. The first hindrance I see is discrepancies between research findings and psychodynamic theory. It is unclear how various developers of STDP and clinicians will resolve these discrepancies. For example, Sifneos continues to believe that only those with oedipal conflicts are appropriate for his form of STDP. This seems to result from his theoretical bias rather than genuine research findings. Secondly, the field of STDP is somewhat divided between different forms of STDP which may hinder the generalizability of research findings. While there is some communication between the various developers of STDP, often these developers' research is designed primarily to test their individual techniques. It becomes unclear, therefore, how a study's findings using one form of STDP applies to another form of STDP. A promising alternative to these two above dilemmas is the recent work of Strupp and Binder (1984). Their work appears to be based more upon the findings of

psychotherapy research than upon the work of a specific theorist or STDP developer.

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